# Medicaid Managed Care Ventilator Services

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# Topics

- Service Coordination
- Money Follows the Person
- Hospital Transition Teams
- Sustaining Community Members
- Services and Authorization
- Tools that Promote Success

# Overview

- People do best in home environment
- Each person has their own unique care needs
- Primary importance is  health and safety
- Use of  professional staff  for training and education is key.
- Flexibility to make  services adjustments to address individual care needs promotes success

# Service Coordination

Roles & Program Goals

(***With respect to clinically complex and ventilator dependent members***)

**Service Coordination is an integral service and the main feature of the STAR+PLUS program**

# Service Coordination Program Goals

**The goals of the Service Coordination Program are to:**

- Ensure long term services and supports (LTSS) and clinical programs are in place according to members wants and needs
  - Accomplished through a comprehensive approach that includes assessments targeting functional, medical, behavioral and social needs
- Support members desires to live in the least restrictive setting as possible

# Level 1 Service Coordination

- Level 1 Service Coordination includes members:
  - Who receive services under the Home and Community Based STAR PLUS waiver services
  - Residing in nursing facilities (except for nursing facility members on hospice)
    - If a nursing facility resident is receiving hospice services, the MCO SC must make at least two telephonic service coordination outreach contacts annually.
  - Who have a severe and persistent mental illness (SPMI) diagnosis
  - Who have complex medical needs
- MCOs must provide Level 1 Members with a single identified person as their assigned Service Coordinator.
- All Level 1 Members residing in the community must receive a minimum of two face-to-face service coordination visits annually.
  - Nursing facility residents receive a minimum of four required face-to-face visits annually.
    - Visits include assessing viability of return to the community
  - Members with SPMI must receive one telephonic service coordination contact annually in addition to the minimum of two annual face-to-face service coordination contacts.

# Nursing Facility Service Coordination

**Service Coordination for nursing facility residents includes:**

- Identifying and addressing residents' physical, mental or long term needs
- Ensuring that care is holistically integrated and coordinated
- Finding ways to avoid preventable hospital admissions, readmissions, and emergency room visits, most importantly benefitting the members
- Finding providers to address specific needs
- Coordination of resident transitions to the community
  - Work with resident, family, nursing facility staff, and relocation contractors to arrange for community based supports (e.g., housing, utilities, legal) and services (e.g., medical transportation, home health, durable medical equipment)
  - Coordinate services with Medicaid and Medicare providers

# Service Coordination: Transition planning

**Prior to relocation to the community, the MCO Service Coordinator ensures that:**

- Interdisciplinary discharge planning meeting occurs prior to NF discharge
- Residents and members of their informal support system are trained on care tasks and equipment usage while still in the facility
  - Evidence of return demonstration should be documented
- Follow up appointments are scheduled, all needed services are in place, and equipment is ordered, set up and tested prior to relocating member
- Specialty services and trained providers are in place

# Service Coordination: Community Placement

**Once the ventilator dependent individual has moved to the community, the MCO Service Coordinator ensures that:**

- Services and equipment have been coordinated and delivered in a timely manner
- Expedited authorizations for the PAS attendant training are processed
- Higher attendant hours are approved to accommodate the transition and training of the attendant
- Back up Plan has been documented and put into place.
  - Back up generators/battery packs for ventilator
  - Service back up plan in the event of the attendant not showing up
- Durable Medical Equipment (DME) Company has a 24 hour on call Respiratory Therapist or Registered Nurse available
- Skilled nursing visits are "front loaded" to teach, train, and monitor
- Physical Therapy is in place to train informal supports on transfers and mobility related activities in the members home environment, evaluate for additional medically necessary DME, and perform a home safety evaluation
- Frequent follow up calls/visits by the Service Coordinator to evaluate service needs and supports

# Money Follows the Person

Transitions from Institutions to the Community

# Goals for Transitions

- Promote independence
- Focused on Person Centered Care
- Offer the least restrictive environment
- Ensure health and safety
- Minimize reinstitutionalization
- Educate member/family to make informed decisions

# Transitions from Institutions to Community

**Nursing Facility Residents who desire relocation to the community and/or request assistance to transition may be identified in several ways including:**

- Individuals referred from the state Program Support Unit
- Minimum Data Set (MDS) Assessment, Section Q
- During a quarterly face to face assessment with the resident by the MCO Service Coordinator
- During interdisciplinary care plan meetings
- At admission, when initial nursing and social service assessments are completed
- NF social worker or other nursing facility staff
- Family/Friend/Representative
- The NF Ombudsman
- Relocation Specialist
- During a hospital stay

**A request to transition may be made at any time by contacting the MCO Service Coordinator.**

# Transition Team Members

- Service Coordinator leads the transition process
- Member, family, legal representative, and others identified by the member
- Nursing Facility interdisciplinary team, including therapy staff
- Physician or physician extender
- Relocation Contractor
- Community Agencies who may support the success of the transition
- MCO Medical Director, as needed
- Ombudsman, if involved
- Local authority, if applicable
- Other ancillary providers as needed (i.e., hospice staff, psychologist, respiratory therapist)

# Core Steps to Transition

- Exploration of the individual's desires and preferences
- Each transition is treated individually: unique and specific to the member's needs
- Coordination is a key principle to ensuring a successful transition.
- Assessment to evaluate the members:
  - Cognitive and Functional abilities
  - Informal Support Systems
  - Housing Plan
  - Medical Services
  - Home visit to assess home environment and possible barriers to transition
  - Community Service and Support Needs

# MCO: Transitioning to Discharge

**Formal and Informal discussions including:**

- Discussions with the member/family/involved others
- Nursing Facility Interdisciplinary Team
- Community Transition Teams
- Internal Interdisciplinary Team

**Member, family, legal authorized representative and caregivers are educated on the process and service array in order to make an informed decision related to return to the community throughout the process.**

# Service Coordination following Community Reintegration

## The MCO Service Coordinator is responsible for:

- Ensuring all needed equipment is delivered on the day that the member moves to the community
- A handoff from NF SC to Community SC to ensure continuity of member's care
- Providing contact information to the member and their support system to reach the identified Service Coordinator, the agency, other service providers and community resources as needed
- Conducting a follow up visit within 14 days after relocation or sooner depending on member's needs
- Contacting the PCP and specialists to coordinate/collaborate services
- Completing required home visits to assess for changes in condition.
- Making all necessary referrals to meet preventative and interval physical and mental health needs
- Educating, monitoring, and identifying the complex needs for our members receiving ventilator services

# Hospital Transition Teams

From Hospital to Home

# Hospital to Home: Care Management

- Discharge Planners and Concurrent Review clinicians meet and collaborate with member/family and other health care professionals to review home **care and equipment needs**
- Members on ventilators receive **intensive service coordination and transition services** to ensure community success and reduce likelihood of readmission
- **Education and training** needs are identified during hospitalization
- **Expectations** concerning home care and training needs are determined using a Person Centered approach prior to leaving the hospital.

# Hospital to Home: Planning for Care and Equipment Needs

- Discharge planners and case managers evaluate equipment needs and ensure proper equipment is delivered to the home
- A home assessment is conducted to ensure removal of barriers and a safe environment for ventilator needs
- Attendant hours are established or reviewed for adequate coverage to provide quality care (attendant hours may increase temporarily after a hospitalization or temporary change in condition)
- Home health services put in place as ordered by the Primary Care Provider (skilled nursing visits/ongoing attendant education)

# Hospital to Home: Planning for Education Needs

- Ongoing education during hospitalization through discharge planning
- Member/family training on activities related to ventilator care during hospital stay with opportunities for return demonstration
- Follow-up education at home with home health agency (recommend more than one attendant/informal support with knowledge of ventilator use)
- Backup plan in place to include Durable Medical Equipment and attendant services that meets the needs of the ventilator dependent member

# Hospital to Home: Intensive Care Management

- Case Managers/Service Coordinators review precipitating factors: situations or conditions that led to hospital admission
- "Red Flag" management: Identify triggers and behaviors related to condition (when to contact physician)
- Medication management: reconciliation of post-discharge medications
- Follow up: ensure coordination of care through member's PCP
- Specific education on disease condition and disease management

# Barriers to Relocation

- Member or their legal guardian does not desire relocation
- Housing availability
- Lack of support to ensure for the health and safety of the member receiving ventilator services
- Medical Instability warrants frequent medical interventions that cannot be supported

# Tools for Success

- Discharge planning begins at admission
- Each individual receiving ventilator services is unique, as are their care needs
  - Person Centered Approach is used during discharge planning to identify members' needs and incorporate their preferences into their individualized Plan of Care
- It takes a team
- Ability to flex services based upon individual need
- Home Safety Visits
- Services and other resources identified are based upon individual need and are coordinated by the team to make all transitions a smooth

**Communication + Ongoing Coordination= Successful Transition**

# Service Delivery

## Sustaining & Supporting Community Living

# Service Delivery Models

- Agency Option
- Service Responsibility Option
- Consumer Directed Option

# Service Array

- Personal Attendant Services
- Skilled Nursing
- Therapy
- Minor Home Modifications
- Respite
- Protective Supervision
- Adaptive aids, medical supplies and specialty DME
- Dental services
- Employment Assistance and Supported Employment

# The Attendant

- Must be 18 years of age
- Cannot be a spouse or legal guardian of a child
- Providers may reside in the home of the member in STAR+PLUS programs
- Family may be the paid service provider in STAR+PLUS programs
- Provide tasks purchased from the Person-Centered functional assessment
- Training by the employing entity
  - Agency model
  - Consumer Directed Services model

# Service Authorizations

- MCOs contract with Home Health and DME providers that offer ventilator services and equipment
  - DME show families how to use equipment
  - Home Health providers are used for additional training
  - Home Health agencies have on call staff to trouble shoot
- Service authorizations are effective for one year
- Service authorizations are renewed/generated with annual reassessments or with a change of condition

# Questions

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